Case ID _____

Fax PAGES 2-7 to 404-639-3866 ATTN: Erin Kennedy

2009 H1N1 Patients and Deaths with Suspected Hemorrhagic Pneumonitis Syndrome

Cover Page: Patient Identifying Information

DO NOT send page 1 to CDC with patient identifying information.
Please remove and store in a secure location.

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Individual Case ID: _____ *Please use the following format to assign an individual case ID for each case reported. State-HPS-## (Example TX-HPS-01, TX-HPS-02)*

Hospital MR # _____

Suspected Hemorrhagic Pneumonitis Syndrome (HPS) can be considered in a patient with all of the following:

- Confirmed 2009 H1N1 virus infection, and
- Clinical or radiographic evidence of pneumonia, and
- Acute onset of illness accompanied by dyspnea and hemoptysis, and
- Severe respiratory illness requiring mechanical ventilation or resulting in death

OR

- Confirmed H1N1 virus infection, and
- A bronchoalveolar lavage (BAL) specimen with hemorrhagic fluid, or hemosiderin laden macrophages on Prussian blue staining

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: ____/____/____

Case ID _____

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Reporter information (person completing form)

Name _____ Date of form completion: ____/____/____

Institution: _____ Address:_____

City _____ County: _____ State ___ ___ Phone number: (_____) _____-_____

Patient Demographics and Case Status

Individual case ID: _____

Hospital MR # _____	Place hospitalized: (city, county, state):
Place of residence (city, county, state):	Country of birth:
Age _____ □ years □months	Sex: □ Male□ Female

Race: □White □ Black □ Asian □ Native American
□ Native Hawaiian/Pacific Islander □ Multiracial □ Unknown □ Other_____

Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown □ Other _____

Has patient resided in an institutionalized setting (e.g., shelter, prison) within the last year? □ Yes □ No □ Unknown

If yes, describe: _____

Medical history

Does the patient have any of the following medical conditions? Check all that apply and specify where indicated.

□ Asthma □ COPD □ Other chronic lung disease _____

□ Diabetes mellitus □ Morbid obesity □ Hypertension

□ Chronic cardiovascular disease (excluding HTN)_____

□ Pregnancy: estimated gestational age, in weeks _____ □ Kidney disease_____

□ Cancer in last 12 months _____ □ Immunosuppressive condition_____

□ Neurologic/neuromuscular condition (incl. seizure disorder, developmental delay) _____

□ Hemoglobinopathy (e.g. sickle cell disease) _____

□ Clotting or bleeding disorder(s) _____

□ Auto immune disease(s) _____

□ Embryonic development disorder(s) (e.g. arteriovenous malformations) _____

□ Other chronic disease(s) _____

Has patient ever been diagnosed with pulmonary tuberculosis (TB)? □ Yes □ No □ Unknown

Patient Height _____ (*Circle cm or inches*) Weight on admission (or first recorded) _____(*Circle lbs or kg*)
If pregnant, pre-pregnancy weight, if known_____(*Circle lbs or kg*)

Case ID ________________

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Health care encounter history, hospital presentation, and admission

Date of symptom onset (fever or respiratory symptoms) ____/____/____ ☐ Unknown

Date of hemoptysis onset ____/____/____ ☐ Unknown

Did the patient seek health care for this illness? ☐ Yes ☐ No ☐ Unknown

If patient did seek health care for this illness, please fill out table below.

In/Out column: Please write an "O" in this column if patient was an outpatient. Please write an "I" in this column if patient was admitted to a hospital.

Other columns: T=Temperature, HR=heart rate/pulse, BP=blood pressure, RR=respiratory rate

In/Out	Date of visit	T	HR	BP	RR	Presenting symptoms	Treatment provided

For every inpatient encounter, please complete the following:

Date of admission: ____/___/____ Date of discharge: ____/___/____ Disposition:__________________	Was patient admitted to ICU? ☐ Yes ☐ No ☐ Unknown Date of admission: ___/____/_____ Date transferred out of ICU: ____/____/____
Date of admission: ____/___/____ Date of discharge: ____/___/____ Disposition:__________________	Was patient admitted to ICU? ☐ Yes ☐ No ☐ Unknown Date of admission: ___/____/_____ Date transferred out of ICU: ____/____/____
Date of admission: ____/___/____ Date of discharge: ____/___/____ Disposition:__________________	Was patient admitted to ICU? ☐ Yes ☐ No ☐ Unknown Date of admission: ___/____/_____ Date transferred out of ICU: ____/____/____

Presenting diagnoses *(ICD-9-CM code and/or text):*____

____

____

Illness severity

During the course of the illness and hospitalization, did the patient require or have:

Mechanical ventilation? ☐ Yes ☐ No ☐ Unknown

If yes, specify type: ☐ Invasive (intubation) ☐ Non-invasive (nasal/face mask) ☐ ECMO ☐ Other______________

If yes, specify the number of days on mechanical ventilation: ______________________

Any vasopressor or inotropic medications to maintain blood pressure? ☐ Yes ☐ No ☐ Unknown

Acute respiratory distress syndrome (ARDS)? ☐ Yes ☐ No ☐ Unknown

Severe sepsis? ☐ Yes ☐ No ☐ Unknown

If yes, onset date: ____/____/____

Multi-organ system failure? ☐ Yes ☐ No ☐ Unknown

Pulmonary embolus? ☐ Yes ☐ No ☐ Unknown

DIC? ☐ Yes ☐ No ☐ Unknown

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Medications – Antivirals and Antibiotics

Did patient receive antiviral medications to treat or prevent influenza, either before or during hospitalization?

Oseltamivir (Tamiflu) □ Yes □ No □ Unknown Date initiated ____/____/____ Stopped ____/____/____

Zanamivir (Relenza) □ Yes □ No □ Unknown Date initiated ____/____/____ Stopped ____/____/____

Other _____ □ Yes □ No □ Unknown Date initiated ____/____/____ Stopped ____/____/____

Did patient receive antibacterial medications prior to hemoptysis? □ Yes □ No □ Unknown

Antibiotic _____ Date initiated ____/____/____ Stopped ____/____/____

Antibiotic _____ Date initiated ____/____/____ Stopped ____/____/____

Antibiotic _____ Date initiated ____/____/____ Stopped ____/____/____

Antibiotic _____ Date initiated ____/____/____ Stopped ____/____/____

Antibiotic _____ Date initiated ____/____/____ Stopped ____/____/____

Antibiotic _____ Date initiated ____/____/____ Stopped ____/____/____

Other Medication History

Medications during hospitalization:

□ Corticosteroids, specify type: _____

□ Proton pump inhibitors (Prilosec, etc.), specify type:

□ Anticoagulants (Coumidin, heparin, etc.), specify type: _____

Current Medications (outpatient), including over the counter medications:

□ Statins/anticholesterol drugs _____

□ Arthritis medications _____

□ Diet pills and diet aids _____

□ Diabetes drugs _____

□ Blood thinners (Plavix, etc)_____

□ Herbal supplements_____

□ Aspirin/NSAIDS _____

□ Heartburn, Indigestion, Ulcer, GERD medications

- □ Calcium carbonate antacids (Tums, etc.)_____
- □ Proton pump inhibitors (Prilosec, etc.) _____
- □ H2-receptor antagonist (Zantac, etc.) _____

Other notes of interest or significance:

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Laboratory testing

Was an AFB test performed? □ Yes □ No □ Unknown

If yes, was it positive? □ Yes □ No □ Unknown

Was a BAL performed? □ Yes □ No □ Unknown

If yes, when? ____/____/____

If yes, what were the results? _____

_____

Were bacterial cultures performed during the first five days of hospitalization? □ Yes □ No □ Unknown

If yes, were any positive? □ Yes □ No □ Unknown

If any positive, please fill out table below.

Site (blood, etc)	Date collected	Organism

Were viral cultures performed at any time during hospitalization?: □ Yes □ No □ Unknown

If yes, were any positive? □ Yes □ No □ Unknown

If any positive, please fill out table below.

Site (blood, etc)	Date collected	Organism

Laboratory testing values on admission to hospital:

(Please provide values of tests performed within 24 hours of admission)

Hematocrit: _____ Platelet count: _____ HgB: _____

PT: _____ PTT: _____ INR: _____

D Dimers: _____ Date performed: ____/____/____

Laboratory testing values at onset of hemoptysis:

(Please provide values of tests performed within 24 hours before or after hemoptysis. If patient had hemoptysis on admission, please provide the values in the space provided above)

Hematocrit: _____ Platelet count: _____ HgB: _____

PT: _____ PTT: _____ INR: _____

D Dimers: _____ Date performed: ____/____/____

Hematocrit: _____ Platelet count: _____ HgB: _____

PT: _____ PTT: _____ INR: _____

D Dimers: _____ Date performed: ____/____/____

Hematocrit: _____ Platelet count: _____ HgB: _____

PT: _____ PTT: _____ INR: _____

D Dimers: _____ Date performed: ____/____/____

Was any other significant laboratory or pathology testing performed?

If yes, please list the test, test date, and findings:

_____

_____

_____

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Radiologic findings

Did patient have a chest X-ray or chest CT within 24 hours of admission? □ Yes □ No □ Unknown

If yes, please list date and findings:

Date: ____/____/____ Study: □ Chest X-ray □ CT

Radiology Report:

_____

_____

_____

If hemoptysis began greater than 48 hours after admission to the hospital, did the patient have a chest X-ray or chest CT on day of hemoptysis onset? □ Yes □ No □ Unknown

If yes, please list date and findings:

Date: ____/____/____ Study: □ Chest X-ray □ CT

Radiology Report:

_____

_____

_____

Outcomes

What was the outcome of the patient? □ Alive □ Died □ Unknown

If alive, when was the patient discharged from the hospital? ____/____/____

Where was the patient discharged to? □ Home □ Nursing facility □ Other: _____

If alive, what was their discharge diagnoses) (text and ICD-9)_____

If alive, and currently still hospitalized, indicate ICU or general bed? _____

General condition of patient (stable, critical, improving, etc.)?_____

If died, please list date of death: ____/____/____ Was an autopsy performed? □ Yes □ No □ Unknown

If died, please list cause(s) of death (*text and ICD codes for all ones listed*) _____

_____

Vaccination history

Did the patient receive the Novel H1N1 vaccine in 2009 at least 2 weeks prior to hospitalization? □ Yes □ No □ Unknown

Did the patient receive seasonal influenza vaccine in 2009 at least 2 weeks prior to hospitalization? □ Yes □ No □ Unknown

Thank you for your cooperation and time.

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Please contact Erin Kennedy (404-639-1234, ftw3@cdc.gov) if you have any questions or concerns.

Case ID ________________

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Pathology specimens sent to CDC

Submitter information

Name ____ Date of submission: ____/____/____

Institution: _________________________ Address:____

City ____________________ County: ________________ State ___ ___ Email: ___________________________

Phone number: (_____) _____-________ Fax (_____) _____-________

Specimen ID # _____________________ Collection date ____/____/____ ☐ Biopsy ☐ Autopsy

Tissue(s) ________________________________ ☐Frozen ☐Fixed

****

Specimen ID # _____________________ Collection date ____/____/____ ☐ Biopsy ☐ Autopsy

Tissue(s) ________________________________ ☐Frozen ☐Fixed

****

Specimen ID # _____________________ Collection date ____/____/____ ☐ Biopsy ☐ Autopsy

Tissue(s) ________________________________ ☐Frozen ☐Fixed

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****

Specimen ID # _____________________ Collection date ____/____/____ ☐ Biopsy ☐ Autopsy

Tissue(s) ________________________________ ☐Frozen ☐Fixed

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